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Case No: HQ 17 X 04194

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION

Royal Courts of Justice
Strand, London, WC2A 2LL

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Before:

MR JUSTICE SOOLE

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Between:

(1) DR STEPHEN JONES **(2) DR RESHMA RASHEED** **(3) DR MITA ROY** **(4) DR MEENAKSHI RAWAL**	Claimants/ Applicants
- and -	
NHS COMMISSIONING BOARD	Defendant/ Respondent

- -
- -

Mr Jason Coppel QC and Mr Steven Woolf (instructed by Taylor Wood Solicitors) for the Claimants/Applicants
Mr Vikram Sachdeva QC and Ms Katie Scott (instructed by Browne Jacobson LLP) for the Defendant/Respondent

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Approved Judgment

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MR JUSTICE SOOLE:

1. This is the application of the Claimant doctors for an interlocutory injunction against the defendant ("NHSE") to restrain it from terminating the standard general medical services contract ("NHS contract") pursuant to which the Claimants have been providing medical services to NHS patients in the Rigg Milner Practice from two surgeries, namely at 2 Bata Avenue, East Tilbury, Essex and Corringham Health Centre, Gifford Cross Road, Corringham, Essex. NHSE cross-applies for an interlocutory.

2. On 24 November before Nicola Davies J, NHSE undertook not to terminate injunction to put in place an alternative "caretaker provider", College Health Limited, to deliver these services from those two surgeries. the NHS contract pending judgment or further order. Upon that undertaking the Claimants' application was adjourned to this hearing on 6 and 7 December. By agreement of the parties I am also dealing with the cross-application.

3. The background to this dispute needs to be set out in some detail. On 17 September 2012 the NHS contract was entered between NHSE's predecessors for these purposes (South West Primary Care Trust (PCT)), and the first Claimant Dr Jones and Dr G.P. Byrne. By schedule 1 of the NHS contract they were identified as Contractor in the following way:

> "The Contractor is a partnership under the name of Dr SR Jones & Partners carrying on business at The Rigg Milner Medical Centre, 2 Bata Avenue, East Tilbury, Essex, RM18 8SD."

4. That NHS contract was entered pursuant to the provisions of the National Health Service (General Medical Services Contract) Regulations 2004. These have been replaced by the 2015 Regulations of the same name (the 2015 Regulations). It is agreed that they contain no material differences for the purpose of these applications and that the NHS Contract terms are intended to reflect the Regulations.

5. The primary legislation, now contained in s.9 of the National Health Service Act 2006, provides by subsections (5) and (6) as follows:

> "(5) Whether or not an arrangement which constitutes an NHS contract would apart from this subsection be a contract in law, it must not be regarded for any purpose as giving rise to contractual rights or liabilities.
>
> (6) But if any dispute arises with respect to such an arrangement, either party may refer the matter to the Secretary of State for determination under this section.

6. When the Contractor is a partnership, the NHS contract provides that it subsists through changes in the membership of the partnership. Thus Schedule 1:

> "The names of the partners at the date of signature of this Contract are Dr S.R. Jones Dr G.P. Byrne.
>
> The Contract is made with the partnership as it is from time to time constituted and shall continue to subsist notwithstanding:
>
> (i) the retirement, death or expulsion of any one or more partners; and/or

(ii) the addition of any one or more partners.

The Contractor shall ensure that any person who becomes a member of the partnership after the Contract has come into force is bound automatically by the Contract whether by virtue of a partnership deed or otherwise."

Notice of such changes must be given by the partnership to NHSE; see clauses 460 and 461.

7.Notices of such changes were given in April 2016 upon Dr Samrath Cheema joining the partnership and Dr Byrne retiring; and upon the second to fourth Claimants becoming partners in July 2016. The latter notice dated 21 June 2016 is headed "Notice of Variation to your General Medical Services Contract dated 17th September 2012." The second page of the document identifies "The names of the partners at the effective date of signature of this contract" as the Claimants and Dr Cheema.

8.A dispute subsequently arose between the Claimants and Dr Cheema. On 20 September 2017 Dr Cheema issued High Court proceedings. A central issue was whether (as the Claimants contended) they had entered a partnership at will on 1 July 2016 or (as Dr Cheema contended) the second to fourth Claimants had acceded to a partnership agreement entered between him and the first Claimant in April 2016.

9.Following a trial in May 2017 Mr David Pittaway QC, sitting as a deputy judge, found for the Claimants. His Order dated 19 May 2017 made declarations that a partnership at will between the five doctors was entered into with effect from 1 July 2016 and that the partnership was dissolved by the present Claimants' service on 14 October 2016 of a notice of dissolution. The order dismissed the claim and further ordered that "the affairs of the partnership be wound up and that all necessary accounts and enquiries of the partnership be taken and made." The Court of Appeal granted permission to appeal on the issue of whether or not there had been a partnership at will, but dismissed the appeal by Order dated 2 November 2017.

10.On 10 November 2017 NHSE served a notice of termination of the NHS Contract, purportedly pursuant to clauses 559 and 560.10. These entitle NHSE to serve such a notice if "a dissolution of the partnership is ordered by any competent court": clause 560.10. The notice stated that the NHS contract was terminated with effect from midnight on 24 November 2017. The Claimants took objection on the basis that there had been no such order. On the contrary, the declaration of the deputy judge, as affirmed by the Court of Appeal, was that the partnership at will had been terminated by the Claimants' notice served in October 2016.

11.By email dated 15 November the Claimants' solicitors gave notice of challenge to the notice pursuant to s.9(6) of the 2006 Act, thus invoking the NHS dispute resolution procedure which is conducted by the Family Health Service Appeals Unit (FHSAU). The NHS Contract makes provision for this procedure in Part 24 at clauses 518-520, 523-528 and 587-591. The procedure is in respect of "any dispute arising out of or in connection with the contract" (clause 518), which includes "any dispute arising out of or in connection with the termination of the contract" (527). The procedure survives the expiry or termination of the contract (528). Its invocation by the Contractor defers the termination of the Contract until the FHSAU determines the dispute in favour of NHSE or the Contractor withdraws the application, whichever is the sooner (clauses 589-590). This is subject to the 'patient safety' provision in clause 591 to which I will refer.

12.I understand NHSE now to accept that the Court order in the partnership dispute did not satisfy the condition in clause 560.10. However the notice has not been withdrawn and the Claimants' challenge is therefore still pending.

13.By letter to the Claimants' solicitors dated 16 November 2017 and headed "Termination of GMS Contract between Drs Jones, Cheema, Roy, Rasheed and Rawal", NHSE's solicitors stated that:

> "Having considered the contractual effect of your client's actions we have advised our client to rely on the provisions of clause 591 of the GMS contract and proceed with termination on 24 November 2017. NHS England believes this is necessary to protect the safety of the patients."

They asked for confirmation that the Claimants would by 12 noon the following day grant them entry to both surgeries so as to run them as a GP practice.

14. Clause 591 of the NHS contract provides:

> "If the PCT is satisfied that it is necessary to terminate the contract before the NHS dispute resolution procedure is concluded in order to protect the safety of the Contractor's patients or protect itself from material financial loss, clauses 589 and 590 shall not apply and the PCT shall be entitled to confirm by written notice to be served on the Contractor that the Contract will nevertheless terminate at the end of the period that the notice is served pursuant to clauses 558, 559, 565, 569 or 571."

15. At this point, the only notice served was the clause 559/560 notice to which I have referred. The letter also advised that the partnership's registration with the Care Quality Commission ("CQC") to provide regulated services at the Rigg Milner Centre had lapsed on dissolution and that unregistered provision is a criminal offence. This was a reference to provisions of the Health and Social Care Act 2008.

16. By reply dated 17 November 2017 the Claimants' solicitors responded in vigorous terms and described the reliance on clause 591 as "a desperate construct having realised that your client's previous notice was unlawful."

17. By internal NHS email dated 17 November, Dr Alistair Lipp, the Medical Director, responded to a request for advice on "whether NHSE should have concerns about the safety of the patients under the current management of the 5 GPs who constituted the partnership which has now been dissolved by a court order." He responded in these material terms:

> "In recent months the partnership dispute has led to difficulties in professional relationships which have had an impact on the effective running of the practice (clinical governance processes) and stress on practice staff (some of whom have taken time off sick). One of our Clinical Advisers has been involved in assessing clinical governance processes. Earlier this year advice was needed to ensure that prescriptions were issued, signed and authorised by appropriately authorised individuals - as this had not been the case. In August, the clinical adviser noted shortcomings in a number of clinical governance processes:- Information governance, safeguarding, CAS alerts, shared learning, significant events, infection control, attendance at practice meetings. Whilst his overall conclusion was that there were 'no immediate patient safety concerns', the shortcomings constitute a risk to patient safety and advice has given to improve the clinical governance and reduce the risk of patient safety. The poor professional relationships are a contributory factor in the shortcomings in their clinical governance processes.
>
> So the continued management of the practice by these GPs does give me cause for concern on the grounds of risk to patient safety… So my greatest concern in relation to patient safety therefore relates to the dissolution of the partnership which means that: (a) we do not hold a contract with a legally constituted body; and that (b) the CQC registration for services has lapsed - meaning the continued health services is outside the law. This is a clear risk to patient safety."

18. By letter dated 20 November the Medical Director of the proposed caretaker provider, College Health Limited, has advised NHSE:

> "I understand from our previous conversations that the outgoing providers are reluctant to co-operate and are currently refusing me and my team access to the Practices' premises. Whilst this is less an issue in respect of the Corringham Medical Centre, given we share premises with this practice, in respect of the Rigg Milner Medical Centre this carries significant risk as, despite us having an alternative site which is located 0.8 of a mile from the Rigg-Milner Medical Centre, having to ask patients to re-direct themselves to this alternative site undoubtedly could compromise patient safety."

The letter continued by observing that in the time available this was a "very simplistic overview."

19. These observations on patient safety were forwarded to the Claimants' solicitors on 20 November and are emphatically disputed. By an email on 21 November they disputed the allegation of a safety risk and pointed in particular to Dr Lipp's reference to the absence of immediate patient safety concerns.

20. By further notice dated 21 November 2017 addressed to "Dr Jones and Partners, Rigg Milner Health Centre", NHSE purported to terminate the NHS Contract, again with effect from 24 November 2017, pursuant to clause 565. Under the heading "Termination by the PCT for a serious breach" clause 565 provides that:

> "The PCT may serve notice in writing on the Contractor terminating the Contract forthwith or with effect from such date as may be specified in the notice if -
>
> 565.1 the Contractor has breached the Contract and the PCT considers that as a result of that breach the safety of the Contractor's patients is at serious risk if the Contract is not terminated; or

565.2 the Contractor's financial situation is such that the PCT considers that the PCT is at risk of material loss."

Clause 566 and following provide for termination in the event of breaches that are capable of remedy.

21. The alleged breach of clause 565 was described in the notice as follows:

> "We take the view that upon the notice of dissolution dated 29 September 2016 being served on Dr Cheema on 14 October 2016 it was your duty to notify us of the steps being taken to dissolve the partnership at that time. You failed to do so and so we find ourselves in the deeply unsatisfactory situation whereby the Contractor no longer exists and there is a disconnect between the party named on the Contract and the legal entities purporting to provide the services. This places us at risk in accordance with Clause 565 and we are entitled to terminate the contract forthwith."

22. The alleged breach was of clauses 538 and 539, which I must also read. Under the heading "Variation provisions specific to a contract with a Partnership" they provide :

> "538. Subject to clause 540, where the Contractor consists of two or more individuals practicing in partnership, in the event that the partnership is terminated or dissolved, the Contract shall only continue with one of the former partners if that partner is -
>
> 538.1 nominated in accordance with clause 539; and
>
> 538.2 a medical practitioner who meets the condition in regulation 42A of the Regulations,
>
> and provided the other requirements in clause 539 are met."
>
> 539: The contractor shall notify the PCT in writing at least 28 days in advance of the date on which the contractor proposes to change its status from that of a partnership to that of an individual medical practitioner. The notice shall:
>
> 539.1 specify the date on which the Contractor proposes to change its status from that of a partnership to that of an individual medical practitioner;
>
> 539.2 specify the name of the medical practitioner with whom the Contract will continue, which must be one of the partners; and
>
> 539.3 be signed by all of the persons who are practicing in partnership."

The claimants contend that the absence of notice of the dissolution of the partnership involved no breach of clause 538 or otherwise.

23. By letter dated 27 November 2017 to the FHSAU, the Claimants' solicitors gave notice for this second termination notice to be considered under the dispute resolution procedure. The letter requested a stay of both applications pending the High Court determination "which is likely to determine whether the dispute resolution continues or not."

24. In the light of the Court applications and the undertaking given by NHSE on 24 November, no notice under clause 591 has been served. In any event, NHSE now also contends that the NHS contract was automatically terminated upon the dissolution of the partnership at will in October 2016. This is on the basis of the general law and/or the NHS Contract terms. Mr Sachdeva QC accepts that this issue would also be within the jurisdiction of the NHS disputes procedure.

25. By letter to the NHSE dated 6 December 2017, the FHSAU stated that expedition of a case based on clause 591 "… would depend on the reason for expedition when weighed against the need to reach determinations in all of the other cases before the FHSAU. The FHSAU has a full caseload but there is a possibility for prioritising more urgent cases. Although not a party to the current Court action, the FHSAU would of course have careful regard to any observations that the Court made as regards a need for prioritisation. It would seek to comply with the Court's expectations in so far as it is able to do so within its resources and having regard to its duty to the parties in other cases."

The letter continued that, with full co-operation of the parties and if the dispute does not require an oral hearing, it would not be unreasonable to expect a decision within ten weeks of first receiving notification of a dispute relating to clause 591.

26. At an early stage of the hearing, I asked NHSE through Mr Sachdeva as to what steps it would in practice take if there were no order on either application, i.e. would it abide by the status quo until the FHSAU had determined the dispute including Clause 591? After time was given to take instructions, the response was that it would take such steps as it was advised it was lawful to take.

27. The claimants seek injunctive relief on the essential basis that by (i) the threat to serve such a clause 591 notice (ii) the proposal, supported by the cross-application, to introduce a caretaker provider at the surgeries and (iii) the absence of any reassurance in respect of the status quo, NHSE is seeking to steal a march on the NHS disputes procedure. They submit that if the Court were considering such a claim in contract the *American Cyanamid Co v Ethicom Ltd* [1975] AC 396 principles would compel an injunction to maintain the status quo until an expedited trial.

28. Whilst s.9(5) of the 2006 Act bars any claim in contract, Mr Coppel QC submits that there are sufficiently arguable causes of action to establish the necessary "serious issue to be tried". These arise under (i) s.6(1) of the Human Rights Act 1998 and Article 1 Protocol 1 to the ECHR and/or (ii) public law *ultra vires*/ irrationality and/or (iii) the tort of unlawful interference with the Claimants' economic interests.

29. NHSE contends that those suggested causes of action are in each case fanciful and that in any event all the factors in the *Cyanamid* jurisdiction point against the Claimants and in favour of the intervention which it seeks in the interests of patient safety. It further submits that the negative order sought by the Claimants is in substance a mandatory injunction which compels the continuation of the contract with the five partners, i.e. including obligations on Dr Cheema who is no longer a partner; and that in consequence a 'high degree of assurance' on the merits of the claim is required before any order could be made.

30. Given s.9(5) of the 2006 Act, the logical first question is whether the Claimants have an arguable non-contractual cause of action. However I think it convenient to follow the course of both Counsel and first consider the issues which are raised under the NHS contract and which will fall for decision by the FHSAU. Mr Sachdeva rightly accepted that if the discretion under *American Cyanamid Co v Ethicom Ltd* comes into play the Court's view on the merits of those underlying issues may be material. Furthermore, in response to my specific question, neither Counsel sought to dissuade me from expressing comment on these contractual issues in the course of my judgment.

31. I deal in turn with:

(i) The first notice;

(ii) The second notice;

(iii) The proposed notice under clause 591;

(iv) Automatic termination on dissolution.

32. The issue on the first notice is straightforward. There has been no dissolution by order of the Court. In consequence clause 560.10 has not been triggered and cannot be relied on by NHSE. In my view this conclusion is in no way weakened by the supplemental Court order for the affairs of the partnership to be wound up and for all necessary accounts and enquiries. That is a routine further order and was consequent upon the preceding declaration that the partnership at will had been dissolved in October 2016.

33. As to the second notice, Mr Sachdeva first distinguished between a technical and a general dissolution (see Lindley and Banks, 20th Edition, paragraphs 24-01 and 24-02). He accepted that the NHS contract provided for the circumstances of a technical dissolution, i.e. where there was a change of membership, by the Schedule 1 provision which I have cited : see also clause 12. By contrast, the word "dissolved" in clause 538 ("in the event that the partnership is terminated or dissolved") referred to a general dissolution.

34. In this case, there had been a general dissolution in October 2016. The effect of clauses 538 and 539 was that, in that event, the only means of continuing the NHS contract was by nomination of one partner. Thereafter the sole practitioner could invoke the parallel provisions for a change to a partnership (clauses 532-537). However, there could be no direct transition from one partnership to a new partnership. The final stage of Mr Sachdeva's argument was that the failure to nominate one partner under these clauses amounted to a breach of contract. That breach and the risk to patient safety together triggered clause 565.1.

35. Whilst Mr Coppel forcefully questioned each aspect of this construction of clauses 538-539, I think it sufficient for present purposes to focus on the final stage of the argument. In my view clauses 538-539 provide no more than an option for the partners (before dissolution) to nominate one of the partners to continue the Contract. I do not think it arguable that the provision can be construed as an obligation; nor therefore that a failure to exercise the provision can be a breach of contract. If so, the provisions of clause 565.1 cannot have been triggered. In any event, the second notice states that the alleged breach "places us at risk". On the face of it, this is a reference to a risk to NHSE, not to patients. Furthermore, even if the perceived risk is of "material financial loss" it appears to be based on the erroneous belief that a partnership is a legal entity and so that upon dissolution it ceases to exist.

36. I turn to the proposed notice under clause 591. This provides a means for the NHSE, in the identified circumstances, to override the postponement of the termination date which otherwise results from invocation of the NHS disputes procedure. Mr Sachdeva submits that this procedure is not dependent on the validity of the notice which has been served pursuant to one or other of the identified clauses. I consider that this would be a most surprising interpretation and inconsistent with the opening clause (587) of this section, which begins "Where the PCT is entitled to serve written notice". If a notice were served and the resulting dispute referred to the NHS disputes procedure, the validity of the prior notice (already in issue) would have to be considered.

37. In consequence I consider that, if a 591 notice were served and founded on either of the two notices served to date, the Claimants would have good prospects of establishing that such notice was itself invalid. I deal later with the issue of patient safety.

38. As for automatic termination upon general dissolution, Mr Sachdeva points to Lindley and Banks, which states at paragraph 3-49:

> "Similarly, if the contract is of a personal character, which is only to be performed by the individual partners who have entered into it or is otherwise dependent on their particular attributes, a change in the firm will determine the contract by rendering its performance impossible."

By way of analogy he cites *Bue & Anor v Worcestershire PCT* [2010] EWHC 1123 (Admin) where Beatson J, as he then was, emphasised the personal rights in a Personal Dental Services contract between an individual dentist and a PCT (paragraph 26).

39. Clause 16 of the NHS contract provides that:

> "Subject to clause 17, the contract shall subsist unless it is terminated in accordance with the terms of this contract or the general law."

Mr Sachdeva submits that the effect of the general law is to terminate this NHS contract upon a general dissolution.

40. The first difficulty with that submission lies in clause 560.10, relied upon for the first notice, which entitles NHSE to terminate this NHS contract in the event that the Court orders dissolution of the partnership. That provision would be unnecessary if general dissolution resulted in automatic termination. Furthermore, clauses 538-539 are under the 'Variation' conditions of the NHS Contract : cf. the termination provisions in Part 25. These considerations reflect the principle that the effect of general dissolution upon contracts with third parties is ultimately dependent on the construction of the contract in question : see also Lindley & Banks at para.23-207.

41. In this case, there is no dispute that the NHS Contract continues to subsist if there is e.g. a reduction of the partnership from 5 to 4 members by retirement or removal. The question is whether there is a different consequence if a 5-person partnership is dissolved and immediately replaced by a partnership of four. Whilst this is evidently a more difficult question than the notice issues, I consider that, particularly bearing in mind clause 560.10, the Claimants have a good argument on the point.

42. If this were a claim in contract, I consider that the claim would have good prospects of success and that - at least in the absence of pressing concerns of patient safety - the Court would readily grant interlocutory relief pending an expedited trial.

43. As to patient safety, the Court would of course tread most carefully in the face of concerns expressed by the NHSE. In the present case the concerns are essentially focused on:

(i) the legal consequence of a dissolution of the partnership;

(ii) the lapse in the registration of the CQC; and

(iii) alleged shortcomings in clinical governance in the particular context of the partnership dispute (see Dr Lipp's email of 17 November 2017; also his witness statements of 21 and 30 November).

44. Conversely, there is no suggestion of medical incompetence on the part of the Claimants and Dr Lipp's email records that the overall conclusion of the clinical adviser was there were "no immediate patient safety concerns". In the meantime the partnership dispute has been resolved, subject to the accounts and enquiries, and Dr Cheema has removed himself from the practice. He has not worked there since 16 November : see his witness statement of 4 December.

45. As to the effect of dissolution, I have indicated my view that the assumption that this has terminated the NHS contract is highly questionable. Furthermore, the two termination notices, each postdating the Court of Appeal decision, were evidently served on the basis that the Contract was subsisting. Likewise the transcript of a meeting between the parties on 13 October 2017, albeit taking place before the Court of Appeal hearing, shows that it proceeded on the basis that the contract subsisted.

46. As to the CQC, the importance of compliance with registration provisions which impose criminal liability for breach is evident. However the CQC statement of its 'current position' confirms that it has now received an application to vary the registration of the existing partnership by removing Dr Cheema and adding the second claimant Dr Rasheed. Whilst noting a breach of s.10 of the 2008 Act, the statement observes :

> "However, as they have submitted an application to register within a matter of days of being informed that that they are carrying on unregistered, we will use our discretion and will not be taking any action over the breach of section 10 at this stage."

47. The CQC also states that it has not, despite requests, been supplied by NHSE with details of the alleged risk with the partnership. The point has been further blunted by the fact that the proposed caretaker provider, College Health Limited, would itself have to apply to be registered to practise from these surgeries. NHSE's cross-application seeks orders so that College Health Limited can deliver medical services from today, 8th December.

48. As to clinical governance, the partnership dispute has been the focus of concern. The evidence includes the claimants' cancellation of Dr Cheema's clinics in November. However, subject to taking accounts, the partnership dispute has been determined by the court and Dr Cheema is no longer practising from the premises.

49. I turn to the question of the Claimants' cause(s) of action. As is common ground, the effect of s.9 of the National Health Service Act 2006 is that the claimants have no legally enforceable contractual rights against NHSE under the NHS contract : see *Pitalia v NHS Commissioning Board* [2014] EWCA Civ 474. Mr Sachdeva emphasises the subsequent decision of *NHSE v Bargain Dentist.com* [2014] EWHC 1994 (QB) where Elizabeth Laing J identified the legislative policy as having three features:

> "First, NHS contracts must not be regarded for any purpose as giving rise to contractual rights and liabilities. Second, disputes about them are not litigated in the ordinary courts. This follows inescapably from the first feature. Third, such disputes are decided by the Secretary of State under the NHS disputes resolution procedure… This policy is expressed in s.9 of the 2006 Act." (para.2).

She noted the NHS disputes procedure; that the parties agree to be bound by any determination of the adjudicator; and that this procedure can be invoked very easily (paras.32-33). She accepted that equitable remedies may be available where there are no contractual remedies, but not so as to defeat the decision of the FHSAU (paras. 51, 63).

50. Mr Coppel responds with the three non-contractual causes of action already identified and which appear in the draft Particulars of Claim. I will deal with them in reverse order.

51. The claim in the tort of wrongful interference with the claimants' economic interest is pleaded as follows:

> "Further or alternatively, the giving of notice to terminate the contract immediately, notwithstanding the ongoing dispute resolution procedure, and in breach of the HRA and/or public law, would be an unlawful interference by officers of the Defendant…with the Claimant's economic interests. The Defendant is vicariously liable for the said tort."

52. The ingredients of such a tort include that the defendant must have intended to inflict the harm of which complaint is made. Whilst it is not necessary to prove this was the defendant's predominant purpose, it must in some sense be directed against or intended to harm the claimant : see Clerk & Lindsell on Torts (21st edition) para. 24-73, citing *OBG v Allan* [2008] 1 AC 1 and *Lonrho plc v Fayed* [1990] 2 QB 479).

53. Leaving aside all the other ingredients of this cause of action, I am not persuaded that there is any arguable basis that NHSE had the requisite intent.

54. Mr Coppel then contends that public law requirements of rationality and proportionality are engaged. The pleaded object of the claim is "to prevent the Defendant from bringing the Contract to an end, and appointing a replacement contractor, before the dispute resolution procedure has been concluded" (paragraph 21). Paragraph 26 then identifies the cause of action :

> "Further or alternatively, the Defendant would act unlawfully, contrary to its public law obligations were it to proceed to serve notice under [clause] 591 and bring the contract to an immediate end. In the light of the serious objections to termination and in the absence of any real need to prevent the Claimants from continuing to provide services it would be disproportionate and irrational to bring the contract to an immediate end."

55. Mr Coppel submits that NHSE is subject to public law constraints when exercising its contractual powers, citing *R (Molinaro) v Kensington and Chelsea RLBC* [2002] BLGR 336). Those constraints need not be enforced by the judicial review procedure where, as here, the claimant is seeking an injunction: see CPR 54.3(1). In *Molinara,* Mr Justice Elias, as he then was, found that there was a sufficient public law element in the Council's exercise of its discretion under the contract.

56. Mr Sachdeva's essential riposte is that the decision in *Molinara* was founded upon a contract which otherwise existed as a matter of private law. In the present case there are no enforceable contractual rights or obligations. He submits that the invocation of public law is in substance no more than an attempt to enforce contractual rights contrary to s.9(5).

57. I consider that the claimants do have a properly arguable claim based on public law which does not cut across or interfere with the provisions of s.9. On the contrary, I consider that the potential claim complements and supports the statutory scheme. As the

Bargain Dentist decision explains, that scheme provides for the adjudication of NHS contracts disputes through the NHS disputes procedure; and the parties are to apply for a decision of the adjudicator under that procedure.

58. In the present case, the Claimants have referred the disputes arising from the two notices to the FHSAU. In the event that a clause 591 notice is served there will inevitably be a challenge and a further reference to the statutory adjudication. The issue of automatic termination will also fall for decision.

59. If NHSE had indicated its willingness to stay its hand pending the outcome of the NHS disputes procedure on all these matters, I consider there would be no basis of claim. However NHSE have been unwilling to give any such assurance and the Claimants are faced with the prospect of unspecified steps being taken to remove them from their practice at these surgeries before there has been an adjudication. In such circumstances, I conclude that public law may have a complementary role to support the statutory process of dispute resolution. I should add that the statutory provisions (Part 12 of the 2015 Regulations) make no provision for FHSAU to make interim orders. Nor, of course, can FHSAU grant an injunction.

60. As to the Human Rights Act, the Claimants contend that service of a clause 591 notice by NHSE, a public authority, would constitute an unjustified interference with their possessions under Article 1 Protocol 1 and hence a breach of s.6(1) of the Human Rights Act 1998. They identify their relevant possessions as those "in the underlying business of the Practice, both in its goodwill, and income-earning potential and in the equipment and other tangible and intangible assets which are used in the operation of the Practice" : draft POC, para. 23.

61. The primary difficulty with that claim is the decision of the Court of Appeal in *Malik v Waltham Forest PCT* [2007] EWCA Civ 265 which held that the prospect of future loss did not amount to a possession; that the statutory prohibition on selling the goodwill in a NHS practice meant that it had no economic value; and that in consequence the personal right to practise flowing from inclusion in the performers list was not a possession. However the subsequent decision of the ECHR in *Malik v UK*, application number 23780/08, stated that the value of the goodwill was not affected by its unsaleability : see paragraph 99. Thus it appears that the ECHR did not agree with the Court of Appeal, at least to that extent.

62. Although the point did not arise for direct decision in *Breyer Group plc v Department of Energy and Climate Change* [2015] 1 WLR 4559, the Court of Appeal in that case considered both of the *Malik* decisions and did not suggest that the Court of Appeal decision should be reviewed.

63. Mr Sachdeva submits that I am bound by the Court of Appeal decision in *Malik*. Mr Coppel submits that the ECHR decision means that the point remains open for argument, at least at the level of the Court of Appeal. In any event the intangible assets, e.g. the lease of the Tilbury surgery, and the tangible assets and equipment constitute possessions which are threatened by the NHSE's wish to intervene. All of this Mr Sachdeva disputes.

64. The interference on which the claimant relies is the threatened termination of the Contract by service of the clause 591 notice. However NHSE's primary contention is now that the Contract automatically terminated upon dissolution of the partnership in October 2016. In these circumstances, the real object of this claim is to prevent NHSE taking further steps to introduce a new practice until all the termination issues have been resolved through adjudication under the NHS disputes procedure. My conclusion is that I am bound by the Court of Appeal's decision in *Malik* and that the reference to tangible and intangible assets provides no arguably adequate basis for a claim under the Human Rights Act. The real issue in this matter is in my view embraced by the public law claim.

65. I turn finally to the exercise of discretion to grant injunctive relief. Mr Sachdeva submits that the relief which is sought amounts in substance to a mandatory injunction to require the contract to continue. In particular he submits that such an order would compel Dr Cheema to perform the Contract. Citing *National Commercial Bank Jamaica Limited v Olint Corporation Limited* [2009] UKPC 16 at para.19, he submits that the Court must be satisfied to a "high degree of assurance" that at trial it will appear that the injunction was rightly granted. I do not accept either part of the submission. Even if it amounted to a mandatory intention, Lord Hoffmann in *Olint* makes it clear that the "high degree of assurance" will only arise for consideration if it appears that the injunction is likely to cause irremediable prejudice to the defendant : see para.19. The basic principle is that the ourt should take whichever course seems likely to cause the least irremediable prejudice to one party or the other : see para. 17.

66. My conclusion is that the application of that basic principle points firmly to the grant of an injunction in favour of the Claimants. Applying the *Cyanamid* tests in turn, the public law raises a serious issue to be tried, for the reasons given above.

67. Contrary to Mr Sachdeva's submissions, I do not consider that damages would be an adequate remedy. If NHSE sought by one means or another to remove the Claimants from the premises and introduce a caretaker provider there would be consequential disruption to their practice and potentially to their professional reputations. I do not accept the loss could be readily calculable.

68. Insofar as it is asserted that the NHSE may suffer financial loss from the grant of the injunction, the evidence provides no real basis for that conclusion. In any event the Claimants are in a position to give the usual cross-undertakings.

69. As to the balance of convenience, I have of course taken very particular account of the concerns expressed as to patient safety and as to compliance with the requirements of the CQC and the 2008 Act. However, for the reasons given above, I do not consider these concerns to have any real weight.

70. For the reasons given above, I also consider that the Claimants' pending and potential challenges before the FHSAU are weighty.

71.I conclude that the right course is to preserve the status quo, to the extent of restraining the NHSE from taking any further steps on the basis that the Contract has terminated by operation of law or by notice. In short, that NHSE must await the decisions to be made pursuant to the statutory disputes procedure.

72.Whilst I have questioned whether there can be any tenable basis to serve a clause 591 notice, I do not think it right to grant an injunction to restrain NHSE from doing so. Such an order would cut across section 9(5). What matters is that, in the event that such a notice is served and then challenged, the NHSE should await the decision of the adjudicator thereon.

73.It must follow from my conclusion on the Claimants' application that NHSE's cross-application must be refused.

74.I return to the helpful letter from the FHSAU. Whilst conscious of the competing pressures which it faces, I do strongly encourage it to adjudicate on the pending applications (and any fresh application relating to clause 591) at the very earliest opportunity. It is evidently of the first importance that there is clarity and finality about the provision of GP services from these premises.

75.I invite Counsel to consider an appropriate form of wording for my Order.

(Judgment ends)